MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

PATIENT MEDICAL AND FAMILY HISTORY

PATIENT NAME (LAST, FIRST, MI) _____ DATE _____

REASON FOR THIS EVALUATION (What specific questions do you want answered?) _____

_____

DO YOU HAVE ALLERGIES? □ YES □ NO IF YES, please list: _____

ALLERGY or IODINE or SHELLFISH? □ YES □ NO ALLERGY to IVP DYE? □ YES □ NO

PLEASE LIST **ALL** PREVIOUS SURGICAL PROCEDURES: Continue on BACK if needed

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Have you **EVER** had any of the following Cardiac Procedures?

STRESS TEST OF ANY KIND	□ YES	□ NO	Month/Year: _____
ECHOCARDIOGRAM	□ YES	□ NO	Month/Year: _____
ULTRASOUND OF THE LEGS	□ YES	□ NO	Month/Year: _____
CAROTID ULTRASOUND	□ YES	□ NO	Month/Year: _____
RENAL ULTRASOUND	□ YES	□ NO	Month/Year: _____
CARDIAC CATH	□ YES	□ NO	Month/Year: _____
PTCA (ANGIOPLASTY)	□ YES	□ NO	Month/Year: _____
STENTS	□ YES	□ NO	Month/Year: _____
CORONARY ARTERY BYPASS	□ YES	□ NO	Month/Year: _____
PACEMAKER IMPLANT	□ YES	□ NO	Month/Year: _____
DEFIBRILLATOR IMPLANT	□ YES	□ NO	Month/Year: _____
ABLATION	□ YES	□ NO	Month/Year: _____
VALVE REPAIR	□ YES	□ NO	Month/Year: _____
VALVE REPLACEMENT	□ YES	□ NO	Month/Year: _____
If Yes, □ Mechanical □ Pig Valve	□ YES	□ NO	Month/Year: _____

Have you **EVER** had any of the following?

DIABETES	□ YES	□ NO	GOUT	□ YES	□ NO
ANEMIA	□ YES	□ NO	ARTHRITIS	□ YES	□ NO
STROKE	□ YES	□ NO	HIATAL HERNIA	□ YES	□ NO
CHEST PAIN	□ YES	□ NO	ULCER	□ YES	□ NO

PALPITATIONS	☐ YES	☐ NO	GALLBLADDER DISEASE	☐ YES	☐ NO
HEART MURMUR	☐ YES	☐ NO	THYROID DISEASE	☐ YES	☐ NO
ABNORMAL EKG	☐ YES	☐ NO	KIDNEY DISEASE	☐ YES	☐ NO
RHEUMATIC DISEASE	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO	BOWEL DISEASE	☐ YES	☐ NO
BREATHING DIFFICULTY	☐ YES	☐ NO	CANCER	☐ YES	☐ NO
LIGHTHEADED/DIZZY	☐ YES	☐ NO	SKIN LESIONS	☐ YES	☐ NO
HEART ATTACK	☐ YES	☐ NO	PSYCHIATRIC DISEASE	☐ YES	☐ NO
HIGH CHOLESTEROL	☐ YES	☐ NO	UNEXPLAINED WEIGHT	☐ YES	☐ NO

Do you currently use or have you previously used TOBACCO? ☐ YES ☐ NO

If YES, what type? (Please circle one) Cigarette Pipe Cigar Dip/Chew

If CURRENT User: How many years? _____ How many packs/amount per day? _____

If FORMER User: Age Started: _____/Age Stopped: _____ How many packs/amount per day? _____

Do you drink ALCOHOL? ☐ YES ☐ NO

If YES, how often? (Please circle one) Everyday Occasional Never

Do you drink CAFFEINE? ☐ YES ☐ NO

If YES, how often? (Please circle one) Everyday Occasional Never

FAMILY HISTORY

Father Living? ☐ YES ☐ NO Age or Age @ Death: _____ Cause of Death? _____
Any Illnesses? _____

Mother Living? ☐ YES ☐ NO Age or Age @ Death: _____ Cause of Death? _____
Any Illnesses? _____

How many Brothers are living? _____ How many Brothers are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

How many Sisters are living? _____ How many Sisters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

How many Daughters are living? _____ How many Daughters are deceased? _____
Any Illnesses? _____ Age/Cause of Death? _____

ACTIVITY HISTORY

What kind of exercise do you do? _____
_____
_____

What is your main hindrance (if any) to exercising? _____
_____
_____